

# ASHA

## Which way forward...?

Executive Summary – Evaluation of ASHA Programme



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## **MESSAGE**

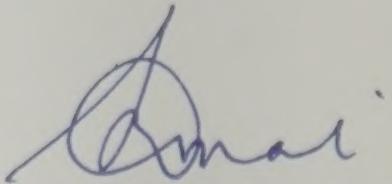


The National Rural Health Mission has fulfilled its promise of one ASHA in every village of the high focus states. With 825,545 ASHAs in the programme, there is one for every 1000 population in almost every part of the country.

I am happy to note that this in-depth evaluation of the ASHA programme conducted by the National Health Systems Resource Center in eight States demonstrates that the ASHA appears to have gained acceptability and recognition from the community and health systems alike. In areas such as mobilisation for immunisation and promoting institutional delivery, ASHA have performed well.

The evaluation also cautions that the potential of the ASHA to make a difference in outcomes related to newborn and child hood deaths is likely to be limited, unless the necessary skill based training, support and supervisory systems are in place. Empowering the ASHA to truly integrate the multiple roles of community mobiliser, activist and provider of first contact care at the community level is the immediate challenge for the programme. The next challenge is the consideration of how to mesh the voluntary and incentivised functions of the ASHA. The third and final challenge is to chart a career path for the ASHA that would build her skills and integrate her in the country's health and human resource strategy.

The key message from the evaluation, therefore, is that there is no longer any question of "Is the ASHA programme working, but, "How do we enable her to realise her potential"? There is a strong and vibrant ASHA programme on the ground. The task that lies ahead of us is to provide the leadership needed to transform the significant investment of human and financial capital into sustainable health outcomes.

  
(K. Chandramouli)  
13/5/11



*National Rural Health Mission*





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## Message



The ASHA programme is one of the cornerstones of the National Rural Health Mission. This evaluation study conducted by the National Health Systems Resource Centre, five years after the launch of the NRHM, provides rich data on the ASHA programme in eight States.

The study findings substantiates global evidence that community health workers, trained and supported, can make a difference to health outcomes.

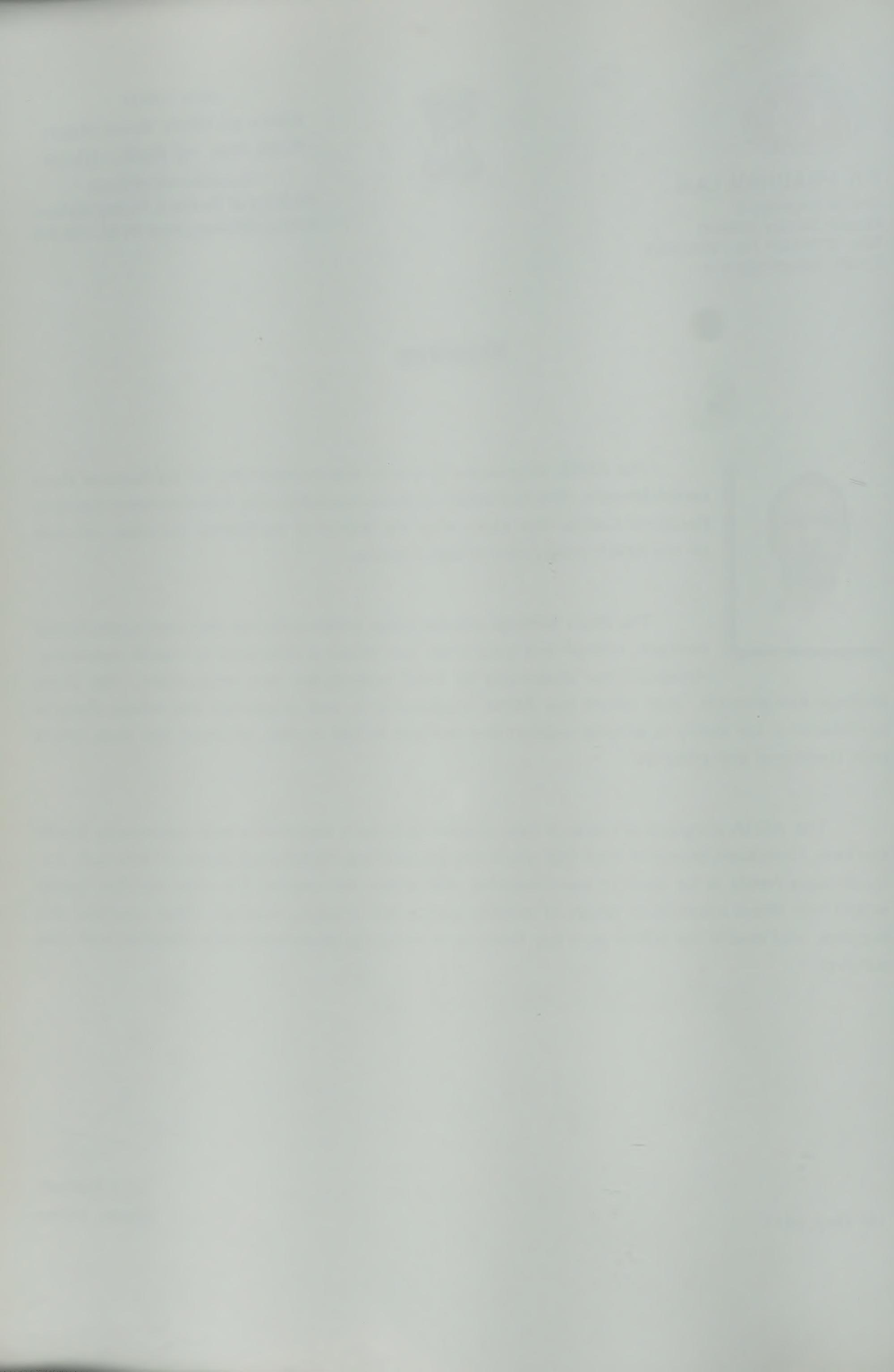
However, the challenges to such support are not insignificant. The study findings demonstrate, that where the ASHA programme is well supported and where there is confidence in her ability to provide support and services to the mother, newborn and child, she is both functional and effective.

The ASHA programme marks a new chapter in India's experience with community health workers. Consistent attention over five years has enabled the ASHA programme to take root, but much more needs to be done to institutionalise this within the system. It's expected that States would now direct attention to issues of training quality and systems, support, timely payment and supplies, and enable the ASHA as a key resource in ensuring improvements in maternal and child survival.

(P K Pradhan)

SS&MD, NRHM

14<sup>th</sup> May, 2011



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**Dr. T. Sundararaman**  
Executive Director, NHSRC

# Evaluation of the ASHA Programme

## I Background

The ASHA programme is a critical component of the National Rural Health Mission (NRHM). The ASHA is a woman selected by the community, resident in the community, who is trained and supported to function in her own village to improve the health status of the community through securing people's access to health care services, enabling improved health care practices and behaviours and health care provision as is essential and feasible at the community level. The ASHA programme was initially included as a part of NRHM for the High Focus states, which comprise Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Rajasthan, Orissa, the North Eastern states, Himachal Pradesh and Jammu and Kashmir. Of these Himachal Pradesh chose not to opt for the ASHA programme. The guidelines also enabled the Non High Focus states and Union territories to select ASHA in tribal, coastal or other difficult districts. Of these, Goa, Pondicherry, Chandigarh, Daman and Diu, did not opt for the ASHA programme. Kerala bartered funding for the second ANM in the sub center, in return for sanction to implement a state-wide ASHA programme. In January 2009, responding favourably to a very positive political and administrative feedback from the states, a decision was taken to extend the programme within even the non high focus states to cover the entire state. Except in Tamilnadu, which kept the programme limited to tribal areas, all other states opted for this expansion. By end 2010, the total number of ASHAs had risen to 825,000. In sheer immensity of what is being attempted this has few precedents.

Today, the ASHA programme has become an inherent part of the health system. Despite this, there are considerable divergences among stakeholder understanding of the ASHA programme and this leads to an interesting variety in the manner in which the programme has been implemented across the states. There is a need for greater clarity on the roles and responsibilities of the ASHA and more effort to improve her effectiveness in bringing about health outcomes.

## Objectives of ASHA Evaluation

1. Understand the evolution of the programme, stakeholder perspectives and experiences of key stakeholders given the specific socio-political and institutional environment.



2. Understand the characteristics of the ASHA, her beneficiaries and her support structures, and her roles.
3. Assess the ASHA's work outputs and attributable health outcomes through measuring programme effectiveness in bringing about changes in health behaviour, utilisation of health services, and responding to community needs especially with respect to common illness in young children.
4. Review quality of key processes and mechanisms that constitute the programme, such as: selection, training, monitoring support structure, and community ownership.
5. Use findings and recommendations of the evaluation to provide feedback to programme managers, ASHAs and other key stakeholders and enable modifications to strengthen the ASHA programme and define her role for the future.
6. Assess the extent to which such evaluations strengthen programme implementation.

## Methodology

The ASHA programme evaluation was conducted in three phases. The first phase consisted of a review of secondary data and use of qualitative research methods, to understand the institutional framework, management processes and perceptions of those implementing the programme, at the national and state level and in two purposively chosen districts. The second phase was a structured sample survey conducted in these same two districts of eight states, one being a well performing district and the second with a high proportion of scheduled castes/scheduled tribes. The districts and states were chosen to capture divergences in contexts so as to give greater opportunity for comparative analysis. The list of states and districts are given below:

Table 1:

State	Selected Districts
1. Andhra Pradesh	East Godavari Khammam
2. Assam	Dibrugarh Karimganj
3. Bihar	Purnia Khagaria
4. Jharkhand	Dhanbad West Singhbhum
5. Kerala	Trivandrum Wayanad
6. Orissa	Angul Nayagarh
7. Rajasthan	Bundi Banswara
8. West Bengal	Malda Birbhum



The survey was administered to the following randomly selected respondents in each district: 100 ASHAs, 600 beneficiaries or service users, 100 Anganwadi workers, 100 Panchayati Raj elected members and 25 ANMs. The service users were classified in two categories (i) Service Users A: (n=400) were mothers of children between 0–6 months, and (ii) Service Users B (n=200) mothers of children of age 6 months to two years who had an illness in the last one month. The details of the selection process are given in the full report. The Anganwadi Worker (AWW), the Panchayati Raj Institution (PRI) member and the Auxiliary Nurse Midwife (ANM) (associated with the ASHAs in the index village) were also interviewed using a structured questionnaire.

Web tables for findings of the evaluation are available on NHSRC website and can be accessed on – [http://nhsrccindia.org/thematic\\_data.php?thematic\\_resources\\_id=1](http://nhsrccindia.org/thematic_data.php?thematic_resources_id=1)

Each of the district and state findings were co-related with the findings from Phase one and each constituted a separate case study. The comparison of the relationships between contexts, perceptions, mechanisms and outcomes in these case studies led to our conclusions and recommendations. This approach draws on both realistic study design<sup>1</sup> and comparative case study approaches to arrive at its conclusions and to provide evidence to support its recommendations. The strength of this approach is that it can factor in how subjective perceptions of implementers and the social and health systems context of a programme influence the choice of programme mechanisms and outcomes.

*In the realistic evaluation technique, the goal is not articulated as the simplistic question: Does the ASHA programme work? but rather as "What Components of the ASHA programme work, and where? Under what Circumstances and to What Extent?" And further – what does it mean when a stakeholder states that the programme works; how do outcomes correlate with the different expectations and perceptions of the programme held by different stakeholders.*

This, we believe, would serve as the basis for dialogue with local, state, and national programme managers, in order to improve the functioning of ASHA programmes for better health outcomes. The third or follow up phase of this study would undertake such a dialogue and document the way these findings and insights are used by programme managers and policy planners. Given the complexity of the programme components, mechanisms, the variability of the context and the large range of eventual outcomes, a framework of analysis was developed, that rests on three distinct questions:

Q1. Who is the ASHA? What is the profile of the woman who has emerged as ASHA? How much time does she spend on her work? How many families does she reach? How has the selection process affected this?

Q2. What are the tasks ASHA is doing (**functional**), to what extent is she **effective** in bringing about a health outcome and what is her **coverage** (the percentage of potential users that she actually reached). Functionality is related to the profile of the ASHA, the expectations of the system

*Service users A – Those who used ASHA's services during pregnancy, child birth or in the newborn period. 400 per district interviewed.*

*Service users B – Those mothers with a sick child in 6 months to 24 months age group who sought ASHA's care. Only sickness in last one month was taken. 200 per district interviewed.*

<sup>1</sup> Rick Pawson and Nick Tilley, Realistic Evaluation, Sage Publications, 2008



as conveyed to her, the incentives provided and the choices she makes in response to the community's needs. **Effectiveness** is related to the knowledge and skills of the ASHA, the responsiveness of the health system in outreach by other service providers, and referral, and the willingness to support ASHA with drugs, and supportive supervision for community level tasks.

Q3. How do functionality and effectiveness (outcomes) relate to programme dynamics? What are the main constraints to effectiveness? Programme dynamics includes management and supervision processes, training, payments, drug kit refills and support from other functionaries and the community.

## II. The Policy Framework and Institutional Mechanisms

### A) Evolution of the Policy Framework and Design

The Policy Framework for ASHA was enunciated as part of the policy framework of the National Rural Health Mission, of which programme it is a component. Its programme design is expressed in the ASHA guidelines issued by the Ministry of Health and Family Welfare in year 2006. At the national level, the guidelines lay out three roles for ASHA: that of a facilitator of health services, of a service provider and that of an activist.



This role definition of ASHA evolved through serious advocacy efforts by concerned civil society activists, resulting in a significant revision of the first concept note of NRHM that was issued by the MOHFW<sup>2</sup>. In 2004, Dr. N.H. Antia, the eminent social health activist and a pioneer in community health worker programmes led a team of civil society representatives to the Prime Minister's office to present a note on the concerns on the narrow definition of the ASHA. This intervention contributed to the creation by MOHFW, of a multi-stakeholder task force to design the ASHA programme and this led to the official definition of the roles and responsibilities of the ASHA. (see Box) The Task Force recommendations are enshrined in the, "**Accredited Social Health Activist Guidelines**," issued by the Ministry of Health and Family Welfare.

Two years later, the Eleventh five year plan further clarified Home based newborn and child care is to be provided by a trained Community Health Worker (such as the ASHA)... During the Eleventh five year plan, ASHAs will be trained on identified aspects of newborn care... To supervise and provide on site training and support to ASHAs, mentor – facilitator will be introduced for effective implementation.<sup>3</sup>

2 Discussion note on the Community Health Worker in the Rural Health Mission, November 28, 2004, in Advocacy Papers on Population Issues, Population Foundation of India, 2010.

3 Eleventh Five year plan 2007-2012, Volume II - Social Sector, National Planning Commission, Paragraph 3.1.131 to 3.1.133.

## Roles and Responsibilities<sup>4</sup>

- ASHA will be a **health activist** in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows.
- ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health and family welfare services.
- She will **counsel** women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunisation, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will **mobilise the community and facilitate them in accessing** health and health related services available at the village/sub-centre/primary health centres, such as Immunisation, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She will **work with the Village Health and Sanitation Committee of the Gram Panchayat** to develop a comprehensive village health plan.
- She will arrange **escort/accompany** pregnant women and children requiring treatment/admission to the nearest pre- identified health facility i.e., Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC/FRU).
- ASHA will **provide primary medical care** for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.
- She will also act as a **depot holder** for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills and Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.
- Her role as a **provider** can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will **inform** about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.
- She will **promote** construction of household toilets under Total Sanitation Campaign.

Fulfilment of all these roles by ASHA is envisaged through continuous training and upgradation of her skills, spread over two years or more.

<sup>4</sup> Excerpted from Accredited Social Health Activist (ASHA) Guidelines, (pages 8-9) National Rural Health Mission, Ministry of Health and Family Welfare, Government of India.

## B) Management and Monitoring Structures for the ASHA Programme

At the national level, the management of the ASHA programme is located within the Training Division of the MOHFW, supervised by the Joint Secretary (Policy), with oversight and guidance from the National ASHA mentoring group. The National Institute of Health and Family Welfare (NIHFW) provided training for state trainers on the first four modules. In December 2006, the National Health Systems Resource Centre (NHSRC) was created to provide technical assistance to the NRHM at national and state levels. Since mid 2007, NHSRC serves as the secretariat for the National ASHA Mentoring Group, providing technical support to the states for the ASHA and other community processes programme, and supporting the Training Division at the MOHFW on policy and operational issues.

At the state level, the programme is led by the Mission Director, supported by an ASHA Resource Centre, to be created for this purpose. Policy guidance and programmatic oversight and some level of technical support are expected to be provided by a specially constituted State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organisations. At the district level, a unit of a District Mobiliser/Coordinator supported by an Accounts/Data assistant is expected to manage day to day functioning at the district level and liaise with the state ASHA Resource Centre. At the Block level, a Block Community Mobiliser with the aid of ASHA facilitators (appointed at a ratio of 1:20 ASHA) are expected to provide the on site support supervision and review of the programme at the ASHA level. This level of management support was considered to be critical to the processes of selection, training, support and monitoring of the ASHA and other community participation programmes.

Establishing a management and support structure has been weak and delayed in all the eight states studied. At the time of the study only Assam had set up the full support structure as per national guidelines. Even Assam clearly needs much more capacity building of its facilitation team. Orissa had a structure in state and district and block level, but not yet at the sub-block level. Orissa had the most functional review process in place, with a clear schedule of meetings and some mechanisms of recording and measuring progress. Rajasthan had all structures in place, but these require more content, depth and skills to be effective. At the time of the evaluation Bihar had no support structures in place, although plans were underway to establish these, and in Jharkhand only state and district structures were in place. In contrast Andhra, Kerala, and West Bengal had no full time support structures in place at any level and were managed by ad hoc appointments of nodal officers who oversaw this work in addition to many other tasks. This bleak scene is ameliorated by some favourable factors. Andhra had a more motivated District Public Health and Nutrition officer, though despite this, it was perhaps the most weakly monitored and supported ASHA of the eight states studied. Kerala had a regular schedule of meetings and the ANM (called JPHN) was much more available for playing this role - as her work had either shifted up to the PHC or been shifted down to the ASHA - making her a supervisor of an ASHA with little work outputs of her own. In West Bengal, panchayat and field functionaries formed a viable administrative support team, though this is of little use in providing clinical support. The nodal agency selected for training played an important



role where the trainers also doubled as facilitators for the ASHA, but that role was limited only to the immediate post training phase. The ASHA guidelines stipulate the role of NGO both in the institutional arrangements and in training. Prima facie, all states except Kerala have involved NGOs in the programme. However, the role of NGOs in all these states has been restricted to training functions, and even here only to logistics management in some states. Much of the weaknesses of the ASHA programme can be traced back to this weak support structure.

## C) Political and Administrative Leadership of the Programme

Poor governance affects programmatic outcomes for the ASHA, not only management of the ASHA programme itself, but also the lack of effectively functioning outreach services and facility (infrastructure, human resources and supplies) care. This latter is also an important factor in ensuring outcomes from the programme. Overall higher political commitment reflected in the willingness to create institutional structures, and insist on a rapid programme rollout on key parameters such as training, creative managerial thinking and a deeper engagement of the leadership with the programme on the ground correlates with a more effective and well supported ASHA programme. In Assam a stable leadership at state level and a dedicated technical agency have served the programme well. This is also seen in Orissa where there is high political commitment to the programme. In West Bengal, Kerala, and Andhra Pradesh while there is commitment to the ASHA programme this is not reflected in the management or support or realised in terms of outcomes. In Rajasthan, Bihar and Jharkhand, frequent leadership changes have hampered programme progress.



## D) Training Curriculum and Training Strategies

In most states, minimum levels of training have been achieved, but the pace of training fell far short of what was required. In Orissa, Assam and West Bengal all five modules have been completed. In West Bengal, 90% had received 23 days of training. In Orissa about 86% received more than 16 days training of which nearly 54% had received more than the targeted 23 days of training. In Assam 77% received more than 16 days, of which 26% had received more than 23 days. In Kerala, 52% had received over 16 days - all had completed module 4. The poorest performance was Bihar, where about 97% of ASHA had received less than 16 days, and 87% had received less than ten days of training over a four year period! In effect for 87% of the ASHAs in Bihar only Module 1 had been covered. In Jharkhand 46% had received between 11 and 15 days of training and 50% received less than ten days. In Rajasthan 31% of ASHA had received less than 16 days of training, with the remaining 69% getting more than 16 days.

The poor pace of training relates almost directly to the human resource that have been deployed for training, either possible to spare within the system, such as seen in Kerala, or sourced in from NGOs as was done initially in Assam, Orissa, Andhra and Jharkhand, or recruited full time, as in the later phase in Assam or Orissa. Where it is based only on internally available, already busy

staff, the training programmes have languished. Training evaluation has also not been conducted in most states in the first four modules.

One of the main weaknesses in the training programme is the content of the training modules, especially of training module 2, which covers a wide number of vitally important RCH topics in too incomplete and superficial a manner and did not even have a trainers/facilitators guidebook accompanying it. Competency based training does not figure in the design of the training modules. This is consistent with an understanding of ASHA as an agent of promoting immunisation and institutional delivery, but not as one who would have skills for provision of community level health care or create change in health care practices.

Despite this the ASHAs seemed to have higher level of knowledge in many areas than what is included in the content of Modules 1-4. On issues such as chest indrawing as a sign of pneumonia, foul-smelling vaginal discharge as a danger sign in the post partum period, and continuing to feed a child with diarrhoea only a modest proportion of the ASHAs knew the right answers. However, even these levels are a positive achievement, since these essential messages are not in the text of the training materials. There are other essential messages which are only mentioned in passing and do not get reinforced. For example on the desirability of adding fats and oils in complementary feeding the level of correct ASHA response averaged to about 21%. This is to be expected since it is mentioned only in passing in Module 1 and it is not mentioned in Module 2. This is also the case with messages such as the need for weighing the newborn child, not giving a bath to the newborn, and drugs to be given for suspected malaria. There are a third set of messages, well emphasised in the training material and which have been transmitted adequately. These relate to referral to the government facility for a complication in pregnancy, early initiation of breastfeeding and duration of exclusive breast-feeding, the importance of handwashing and ORS administration for diarrhea, referral for ARI and contraceptive choices.

Except in Orissa and Assam, states adapted the modules for local context and need. Jharkhand and West Bengal substantially strengthened the message content. Jharkhand even revised the modules entirely, made it more pictorial and richer in key information, and this is reflected in the scores of the ASHA on a wide variety of knowledge areas, which are higher than for Assam, which had a far better supported programme. Rajasthan, Uttar Pradesh and Angul in Orissa supplemented these modules with child and newborn health modules of their own and Kerala included messages on non communicable disease. Andhra Pradesh did not use these modules at all. The received wisdom is that in a training cascade, there is considerable loss of information content down the cascade and evaluation usually interprets training outcomes based on this assumption. That assumption may not be appropriate for this programme. What we see is a pattern of step up in transmission at different levels, but since these were largely spontaneous and varied across states and districts, the net outcomes in knowledge and skill levels also vary.

The only skill that is imparted in the first four modules is the skill to take temperature using a thermometer where the steps are spelt out in some detail, but there is no method to impart this as a skill. The lack of a separate trainer's manual may be a major reason for this. Statistical correlations



show that basic level of education did not have a significant correlation with knowledge levels in any district, except to some extent in Jharkhand's Dhanbad district. It is possible that more educated women have a better background knowledge of some health issues, like making blood slides for fever in malaria or on preparation of ORS and therefore perform better, but it is certainly not due a capacity to absorb information from the books and training programmes better. It is the quality of training which includes how the messages are highlighted in the training material, the transaction of the manuals and most important, training evaluation that determines knowledge outcomes.

## E) Incentive Payments: Patterns and Perceptions

National guidelines for ASHA define her as a "honorary volunteer" to be compensated for her time in specific situations such as training attendance, monthly reviews, and other meetings. In addition she is eligible for incentives offered under various national health programmes and also could be compensated out of the untied funds at the VHSC for specific outcomes. In general all states incentivise the ASHA for JSY and immunisation and participation in review meetings and most incentives received are for these three activities. There are also incentives in most states for identification of candidates for cataract surgery, referral of eligible couples for family planning, acting as DOTS provider, making blood slides in suspected malaria and in support for water and sanitation programme. The efficiency with which these incentives actually reach ASHAs is low, but despite this, ASHAs are active on these tasks. In addition there are many other state specific incentives, which are updated annually and vary from year to year and state to state.

Across the states, most ASHAs are receiving Rs. 500 to Rs. 1000 per month-with the highest being in Orissa followed by Assam. In West Bengal ASHA's receive a fixed sum of Rs. 800 per month and in Rajasthan, a fixed sum of Rs. 950 of which at least Rs. 500 is delivered in an assured manner. In Angul, newborn visits are also incentivised and accounts for the ASHA receiving the highest amounts.

Assam, Orissa and Kerala have robust mechanisms of accounting and timely payment, but as can be expected, net receipts in Kerala are lower since payment is linked to RCH activities. West Bengal has a fixed amount system which is well implemented. Rajasthan has a fixed plus performance based payment system but with weak implementation. The ASHA is functional in fixed payment systems, but the link with JSY as the main focus of her work is diminished. Andhra, Bihar and Jharkhand have performance based payments which are poorly implemented - clearly co-relating with the lack of a management-support structure in these three states. In Andhra Pradesh and Kerala, the problem is compounded by JSY being a poor yield opportunity as only BPL women get the JSY package and anyway fertility rates are much lower. Mode of payment in Orissa, was the bank transfer, in Assam and Rajasthan a mix of all three - bank transfer, cheque and cash; in Jharkhand and AP it was a mix of cash and cheque and it was cash predominantly in West Bengal, Kerala, Bihar.



## F) Drug Kits: Supply and Replenishment

A drug kit is to be provided to the ASHA. The GOI issued model guidelines to streamline refilling of the ASHA drug kit. The contents of the kit were a part of the guidelines, but states have adapted the list in many cases and the list with most frequent adaptations are shown in the box. The kits are expected to be filled monthly. Except in Bihar the drug kit has been provided to all ASHA. Even when the kit has not been provided, ASHA are given some drugs to be dispensed. The major issue is timely replenishment as well as the tension between potential misuse of drugs and the immense advantages of providing first contact care that would save lives and enhance credibility. The key life saving drugs in the kit are ORS, cotrimoxazole and chloroquine (or higher anti-malarial equivalents) and the most side effect prone drugs in the kit are oral contraceptive pills. Findings from Phase 2 demonstrate that where the ASHAs are supplied with drug kits and regular replenishment is being done, both ASHAs and beneficiaries report the use of ORS for management of diarrhoea and appropriate referral - demonstrating the high potential to provide prompt and appropriate management of childhood illnesses at the community level. Paracetamol and dicyclomine provide symptomatic relief, and IFA and albendazole are used in anemia and de-worming - all simple, safe and very effective. The overall picture is of an increasing commitment by the state to provide ASHAs with drugs which are essential for her effectiveness. Timely replenishments on account of poor logistics or incomplete supply and refills due to inadequate emphasis in training programmes limit the ASHA's effectiveness.



### ASHA Drug Kit as per guidelines and manuals

- ORS
- Paracetamol
- Oral Contraceptive Pills
- Condoms
- IFA
- Cotrimoxazole
- Chloroquine
- Dicyclomine
- Albendazole
- Nischay Kit
- Thermometers
- Bandages
- Cotton Swab
- Betadine
- Gentian Violet

## G) Financing of the ASHA Programme

The financial guidelines for the ASHA programme were initially laid out in the Accredited Social Health Activist guidelines<sup>5</sup>, issued by the Ministry of Health and Family Welfare in July 2006. The financial norms for an ASHA, included costs incurred on selection processes including social mobilisation, training, rug kit and un-tied funds to the village and amounted to Rs. 7415 per ASHA. The guidelines also stipulated that the incentive payments would come from the various programmes and thus were not part of this amount. In October 2006, a supplementary set of financial guidelines were issued by the MOHFW to make provision for a support structure from state to sub block levels, and for the supply of identity cards, bags, and badges for the ASHA. The study shows that expenditures were lower in the early years. This is not unexpected, given that states were in the process of establishing the institutional and

<sup>5</sup> Accredited Social Health Activist Guidelines, (ASHA), Ministry of Health and Family Welfare, Government of India.

programmatic structures for NRHM as well as the time taken for start up of the ASHA component. In the three functional years since then, states ought to have spent about Rs. 30,000 per ASHA.

The highest expenditure of all eight states is in Assam amounting to Rs. 12,546, and this correlates with a well performing ASHA programme. It is still only one thirds of what the state should have spent. Orissa reports the second highest expenditures with about Rs. 10,689 per ASHA and is also linked to a strong ASHA programme on the ground. Kerala expanded its programme late, but still reports an expenditure of Rs. 10,689 per ASHA. Rajasthan's estimate of Rs. 7529 over three years may be a serious under-estimate - as the state government spends almost Rs. 500 per month per ASHA on fixed honorarium. West Bengal's Rs. 8300 represents the slower pace of training and the lack of investment in support structures. Jharkhand has expenditure at Rs. 7348 per ASHA. Bihar's expenditures of Rs. 3373 per ASHA is the lowest amongst the 8 states examined and it correlates with the weakest programme - where training is still to take off beyond the first round, and where there is no support structure in place. All states have spent much less than allocated, and the primary reason for this is the inability or unwillingness to invest in management and support structures at state, district and block levels. This is also reflected in poor pace of training and no doubt impacts the quality of training. Expenditure rates are also reflective of the quality of political and administrative support the programme has the willingness to put their money where it matters.

## H) Village Health and Sanitation Committees (VHSCs), Social Mobilisation, and Social Exclusion

VHSC have been formed in Rajasthan, Jharkhand, Assam, Andhra Pradesh and Orissa (referred to as Gaon Kalyan Samiti). In West Bengal, Kerala and Bihar the existing health and sanitation committees of the Gram Panchayats have been designated as the VHSC with differing nomenclature and modifications in membership. Thus the Gram Unnayan Samitis of West Bengal include SHG members and ASHA, the Ward Health and Sanitation Committees in Kerala work closely with the Kudumbashree or the network of SHGs, and in Bihar the existing Village Health Committees of the Gram Sabha have been designated as the VHSC. Except in Kerala, Assam and Orissa, and to a limited extent in West Bengal there is little systematic training of the VHSC members.

Phase 2 evaluation confirms that VHSCs are established in the majority of villages, by ANMs, AWWs, PRI members and ASHAs asked independently. PRI members assessment of the VHSC functionality is about half of the others estimate in Rajasthan (41%) but in other states it is about the same or at best about 10% less. The ASHA is a member of this committee and is expected to attend the meetings, mobilise community and raise issues relating to health in the village. Where established it is generally supportive of the ASHA and usually the ASHA has an important role in this. But in West Bengal such a relationship is established only in 48% of cases and in Jharkhand this is about 66%. VHSCs are not established in Bihar and the process has taken place in only about one fifth of the villages of West Bengal and half the villages of Andhra Pradesh.



**Social exclusion:** A major challenge for the ASHA programme is to ensure equitable service delivery to all community members. This involves understanding issues of inequality and finding local contextual programmatic and implementation solutions. One interesting check on affirmative action to reach marginalised sections was to assess the proportion of service users A from the Scheduled Caste (SC) community and whether this was proportionate to the percentage of SC community in the district. In every one of the 16 districts it was definitely more. In two districts the difference was less than 10%. But in the Andhra districts as against 17% of SC in the districts - 42% of 48% of users were from the SC community. In contrast in the districts of Rajasthan the difference was the least and the percentage of users who were SC being about the same as in the population. In the case of the Scheduled Tribes (ST) community, in almost all districts the percentage of service users A in the ST category is modestly higher than the district proportion of ST.

### **III. Profile of the ASHA and the Process of Selection**

#### **A) Individual Characteristics**

The study shows that in all states, all ASHAs were women and most were married except for 5% in Bundi, 8% in East Godavari, and 12% in West Singhbhum. About 60% of them were in the 24 to 35 year age group, except in Kerala where only 35% belonged to this age group. In Rajasthan and Jharkhand the remaining were mainly in the 20 to 24 age group, whereas in Kerala, Assam, Orissa, Bihar and West Bengal the majority of the remainder were above 36 years of age.

#### **B) Educational Qualification**



Most ASHAs are over 8th class educational level. Most villages have selected ASHAs who are literate, because of insistence from state authorities. Only Orissa, Jharkhand and Andhra Pradesh have relaxed the literacy qualification. In these three states, 37% in Orissa, 27% in Jharkhand and 28% in AP the ASHA reported an educational qualification lower than Class VIII. The inability to relax the educational level where needed and raising the educational level even higher, as in West Bengal to class X has resulted in failure to find ASHAs in some of the neediest areas.

#### **C) Economic Status**

Most ASHAs reported a monthly family income of between Rs. 1000 to Rs. 3000. ASHAs in Kerala, Orissa and Jharkhand are the poorest with 65%, 35% and 22% of families earning less than Rs. 1000 per month. 38% of ASHAs in Assam report a family income of more than Rs. 3000 per month and 13.5% report an income of over Rs. 5000 per month. In Bihar 22% report an income of Rs. 3000 to Rs. 5000 followed by West Bengal with 15% in the Rs. 3000–5000 pm range and 20.7% over Rs. 5000. In Orissa 16% reported a monthly family income of Rs. 3000 to 5000 and 8.5% over Rs. 5000 per

month. The ASHA herself is the main bread winner - 22% in Orissa and 18% in Assam and about 10% in Bihar and Rajasthan while it was only up to 7% in other states.

## D) Social and Community Identity

Most ASHAs come from poor households, and the proportion of ASHAs who are SC or ST is equal to or more than the proportion of the SC/ST population in most states. In the two districts of Bihar, in Trivandrum district and in Birbhum district it is somewhat less (e.g., 10% of ASHAs are SC as compared to 14% SC in the population). Only Andhra shows conscious affirmative action with regard to SC representation. Tribal districts have usually preferred ASHAs from ST background. Minorities are however under-represented.



## E) Access

The density of ASHA deployment varies across and within states, with most states having over 50% of ASHA catering to a population of less than 1000. In tribal areas of Jharkhand, Khammam and Banswara, ASHA density is less than one per 500, in about 25%, 36%, and 19%, respectively, indicating that states have interpreted the norms to suit their contexts to some extent. In West Bengal, 60%, cover more than 1000 population and this can be explained possibly because of high population density. The number of ASHAs who have to cover only one hamlet is 34% or less in all districts except in Andhra, where it is about 62% and Kerala where it is about 65.5%. In Assam, Rajasthan, Jharkhand and West Bengal about 36% to 45% of ASHA cover two to three hamlets while this percentage was less than 30% for the remaining states. ASHAs covering four or more hamlets were highest in Rajasthan and West Bengal, almost 27%. In Wayanad about 10% of ASHAs required an auto or tempo to reach their hamlets but for the most part others reported walking or cycling to reach their hamlets. In Kerala, as high as 77% ASHAs reported a second ASHA working in their village. This was followed by Andhra Pradesh, Bihar and West Bengal with 56%, 52% and 41% respectively while it was less than 30% in the remaining states.

## F) Marginalisation and Access

The Phase 2 evaluation explored whether ASHAs perceived marginalisation and social barriers as an issue and whether they are prioritising and reaching marginalised households<sup>6</sup>. Significant numbers of ASHAs reported the existence of poor and marginalised sections in their coverage area. About 97% of respondents in Orissa said that there are poor and marginalised sections in their coverage area. In AP, Kerala and Assam 85–90% said the same. In West Bengal and Bihar about 72% of respondents said that there are marginalised communities in their coverage area. However, 58% of ASHAs in Dhanbad district of Jharkhand and 62% in Banswada district of Rajasthan said that there are no marginalised or poor sections in their coverage area.

<sup>6</sup> Marginalised communities were defined for the purpose of this evaluation as – SC/ST households, hamlets, houses of migrants, economically backward, households with disabled women, women headed households having a problem with access/utilisation of services.

Of those who stated that there were marginalised sections in that area, a significant percentage also said that it was difficult for ASHAs to access these marginalised households - whether due to distance or due to social barriers.

Perceptions of ANMs and AWW on the existence of marginalisation is limited and much less than that of the ASHA - and the general perception is that ASHA serves "everyone in the village" equally - and there is no special concept of affirmative action to reach the weakest. More ASHAs in contrast report sections which have difficulty in accessing health services, as well as report sections that they have problems in accessing. These problems are also reflected in the poor coverage of services - more so precisely in those districts where perceptions of marginalisation are less.

## G) Subjective Profile of the ASHA

Every ASHA was asked why she chose to become an ASHA from a set of nine responses, and to rank the top three in order of importance. The desire to serve the community emerges as the foremost reason for becoming an ASHA, well above all other factors. 80% of all ASHA across the districts reported "serving the community", as one of the top three reasons. The second most important reason was the financial aspect of being an ASHA. Although only about one in four ASHA reported financial need, as the first reason this accounts for one of the three reasons among 50% of ASHA across the states. The third most important reason, getting a government job was stated as the first reason by only 5% of respondents. For 15% to 30% of ASHA it was one of their first three reasons.

## H) Selection Process

The national guidelines called for a gram sabha or village committee making the selection, with names generated by social mobilisation and the voices of weaker sections facilitated by a trained facilitator. These names were to be endorsed by the panchayat. This has been a very difficult goal to reach. Indeed we find that each of the 8 states studied have used a significantly different process for selection. Despite the multiple narratives of how selections were made, one general finding is that either the ANM or the panchayat member who leads the final decision. Selection by ANM, or panchayat head *acting unilaterally* is reported - but in less than 10%. NGO participation in this process has been negligible except to a very limited - 6% extent in Jharkhand. Many of the fears of poor selection, or selections compromised by considerations of caste or economic status, becoming a major impediment to the implementation of the programme are not borne out.

## I) Time Spent

Across the states, and despite the different modes of selection, 61% to 87% of ASHAs report working three to five hours per day on an average, the lowest being 51% in Dhanbad district of Jharkhand. This is high for a purely voluntary function, and where the ASHA is also engaged in another major income activity.

## **IV. The Functionality and Effectiveness of the ASHA**

One of the most fundamental questions about the ASHA programme relate to her functionality and effectiveness. Functionality of the ASHA is defined in terms of the activities ASHA is carrying out or as the activities on which she spends her time. Effectiveness on the other hand is defined by whether the intended outcomes of these activities are being realised or not. Functionality of the ASHA depends on the policy framework, what she is trained and supported for, her personal understanding of the programme and what she is being incentivised for. Effectiveness or outcomes depend on her coverage, skills, the support/responsiveness from the health systems and the adequacy of her interaction for that context. In the main text these are dealt with separately, but for the purposes of the summary, we have consolidated these into one section.

The vast majority of ASHAs are functional, (i.e., carry out a defined task) irrespective of context and other constraints. There is however a wide variation in the range, coverage and outcomes, and this makes generalisation of any sort difficult.

### **A) Range of Services Provided by the ASHA**

In terms of work ASHAs reported as having done in last six months different states showed different patterns. In all states over 85% of ASHAs reputed that they were 'functional' in two activities - counselling women on all aspects of pregnancy and promotion and coordination for immunisation programmes, with only Jharkhand having a 77% average for both and Bihar having 71% for counselling pregnant women. The third highest activity was visiting the newborn which was higher than 80% in all but 6 of 16 districts. Accompanying women for delivery, the most publicly known activity of the ASHA was above 85% in all districts except Kerala and West Bengal. Another activity reported was household visits. All but eight districts reported above 80%. While it was lowest in West Singhbhum with 46%. 70% of ASHAs reported nutrition counselling from Kerala, Andhra Pradesh and West Bengal, and from Nayagarh, and less than 50% in the remainder. In community level care for illness and use of drug kit, only 70% of ASHA responded positively in Kerala, Khammam and Nayagarh, with a 8.5% in Bihar.

### **B) Coverage or Utilisation of the ASHA's Services**

The two districts of Kerala, Angul in Orissa, and Birbhum in West Bengal record over 80% utilisation by potential beneficiaries for pregnancy care as well as care of the sick child. The two districts of Assam and the two districts of Rajasthan show utilisation by pregnant women of 75% and 77% for care in pregnancy but 67% for care of the sick child. Bihar shows utilisation for pregnancy care by 73% of pregnant women in both the districts. Next with utilisation in the 60% range for care in pregnancy are Khammam in Andhra Pradesh, West Singhbhum in Jharkhand and Nayagarh in Orissa; the rest fall below 60%. Khammam however has a better utilisation of child care. The



lowest figure for utilisation of care in pregnancy was 42.2% of pregnant women from East Godavari, but this district has 73% of beneficiaries reporting utilisation in sick child care. This pattern is also true for the districts of West Bengal, Kerala, Andhra Pradesh and Angul in Orissa where utilisation in care for the sick child is higher than the utilisation figures for pregnancy care. The lowest figures in the range of 45% for service utilisation in case of a child between six months to two years of age who was sick in last one month were from two districts of Bihar and two districts of Jharkhand. The most important learning from this finding and perhaps of the whole study, is that even in the best of situations, even for care in pregnancy which is one of the most emphasised aspects of the whole programme, upto 11% of potential users are being missed by the ASHA, and it rises to as much as 58% in East Godavari, 47% in Malda, 45% in Dhanbad, 33% in Nayagarh of Orissa and so on.

### C) Care in Pregnancy, Promoting Institutional Delivery

One of the tasks, where there is complete consensus that ASHA has a role, is the promotion of institutional delivery. Over 90% of ASHAs are *functional* on this task. One reason for this good performance on this task is incentivisation - as this is the most consistently incentivised activity. It is also one of the most supervised elements of the programme. A third contributory factor is that this activity requires relatively little knowledge or skills, on the job supervision or any other form of support. However even in the promotion of institutional delivery both *coverage and effectiveness* varies. In terms of coverage, in four districts over 80% of pregnant women, (both districts of Kerala, Angul in Orissa, and Birbhum in West Bengal), another nine were in the 60% to 80% range, and the remaining three were in the 40 to 60% range. (East Godavari in AP, Dhanbad in Jharkhand, and Malda in West Bengal). That in the best performing of districts over 20% of pregnant women are not even met, by the ASHA and that in poor performing districts where the ASHA is needed most, as much as half the pregnant women are left out, is a matter of deep concern. Increasing coverage requires that the ASHA reaches out to all - even those who clearly will not opt for institutional delivery - so that she can change behaviours, instead of prioritising her time, only for those most likely to yield her an incentive payment. The analysis of effectiveness below shows that in some states where the ASHA programme are more incentive driven and less mobilisation, there is such a trend. The ASHAs ability to reach out to felt needs of the community, for example by providing drugs for common illness, would also enhance her credibility to promote institutional delivery. Finally a good quality of supervision and review would also identify these gaps and promote better coverage.



In terms of effectiveness, of the pregnant women that the ASHA has met in pregnancy, only a certain proportion opted for institutional delivery and there are four patterns of functionality - effectiveness relationships seen:

- In some states like in Kerala and Andhra Pradesh, the level of institutional deliveries are already high and only about 50% of those who opted for institutional delivery stated ASHA support's as contributing to their choice, and only about 30 to 35% had JSY as a reason for the choice.

- In contrast in Angul, Orissa, about 60% of deliveries still take place at home according to DLHS III. Therefore when we find that 85% of families are met by ASHA and of them nearly 94% report institutional deliveries, this increase clearly reflects ASHA effectiveness. This is further validated when 94% of women who sought institutional delivery said they had been referred by the ASHA.
- In Bihar, 72% of pregnant women were met by ASHAs and 82% of these opted for institutional delivery. However home deliveries account for 75% of all deliveries (DLHS III, for both Khagaria and Purnia) and therefore we are concerned that those pregnant women, not met by the ASHA were the 28% who had home deliveries. Further, in Bihar, 25% of Service Users A who opted for institutional delivery did not name ASHA as a motivator. The high JSY payment efficiency in Bihar, could have by itself been the main motivating factor for women to access institutional delivery. This trend is also seen in Rajasthan, where 76% of pregnant women were met by the ASHA and of these 93% opted for institutional delivery, but DLHS III home delivery figures are in the range of 50% indicating that all the 24% who were not met even once by ASHA during their pregnancy were all those who opted for home delivery. In Rajasthan, 56% of pregnant women A who opted for institutional delivery named ASHA as the motivator.
- By contrast, in Jharkhand, though only 60% of pregnant women were met by ASHA, about half of them did not opt for institutional delivery. By DLHS III data, home deliveries are nearly 80% in West Singhbhum and 65% in Dhanbad. The Jharkhand ASHA is providing as much coverage to home deliveries as to institutional deliveries and is clearly not trying to maximise her incentive earning opportunities in a mechanical and unacceptable way - not a commission agent, and more of a change agent. This pattern is also true of both districts of Assam and West Bengal.

The functionality and effectiveness of the ASHA with respect to three ANC check - ups, post partum care and other aspects of pregnancy management, is much lower than the promotion of institutional delivery in all states except in Kerala and Andhra Pradesh. In Kerala and Andhra Pradesh the high base line in performance of ANC check up at 98% and 90% (DLHS III) respectively could account for the high effectiveness of the ASHA in ANC. On three ANC check ups, there is a significant increase in Orissa and Rajasthan, modest increases in Assam and Jharkhand, uniformly low figure for Bihar, and a small decline in West Bengal. In Orissa, DLHS data is 57% and Service User A data is 70%. In Rajasthan, DLHS III data for the two districts is 26%, and the study data is 52%. In Assam, DLHS III data show 51% against 54% in our study. In Jharkhand, whereas DLHS III average for these two districts is 45%, service user average is 51%. In Bihar, the performance on three ANC check up is particularly poor at 21% by DLHS III and 21% among Service Users A in this study as well. In West Bengal, DLHS III data shows 59% ANC coverage, but the study data indicates only about 49%. Caution must be exercised in interpretation of the West Bengal three ANC data because on indicators such as making an ANC card, TT injection, and for counselling on post partum care and contraception, West Bengal performs reasonably well. In Bihar, by contrast, on all these parameters - the ANC card, the post partum counselling, the counselling on contraception, both functionality and effectiveness is low. The ASHA's knowledge in post partum counselling is low as in West Bengal,





but she performs relatively better in contraception. The outcome of the ASHA's counselling on post partum care in West Bengal is likely to be limited by the low skill level in this area, while the excellent outcomes on contraception relate both to high knowledge levels and possibly better availability of services. This comparison between states on functionality showed ASHA's being functional on health promotion/counselling tasks depends on the support and encouragement given, and this in turn depends on whether she is seen as merely a sort of commission agent - link worker or as an active care provider by those implementing the programme. But effectiveness is a response to the way functionality interacts with the supply side arrangements and the skill levels. A high skill level will not result in better services if the supply side is not in place. (For example, non availability of the ANC card or IFA tablets). However a high skill level and an adequate supply side will not lead to better outcomes if the ASHA is not functional in this area.

## D) Immunisation

A second task for which the ASHA is incentivised is childhood immunisation. We find that functionality on this task of attending immunisation sessions is high across all states. In four states this is above 90% and in the other four it is above 84%. This is high both by ASHA reports, and by triangulating with the data from ANM and AWW reporting. Service Users also confirmed this pattern. ASHA effectiveness on this task varies. On promoting immunisation, the outcomes are consistent with the patterns seen in DLHS III. Since figures from some states are quite low, in DLHS and in our study, the obvious conclusion is, the high level of both functionality and knowledge on immunisation promotion amongst the ASHAs do not translate into health outcomes depending due to supply side factors. In Assam, in both districts over 96% of ASHAs are mobilising for immunisation sessions, and 94% knew the correct timing of measles vaccine. Despite this, only 71% of children in Dibrugarh and 55% of Karimganj had actually received measles vaccine. Variation is also due to the response of ASHAs and local support systems to felt needs in the community, and by the ASHA exercising her own agency in decision making. This has implications both for programme design and for viewing immunisation rates as a consequence of supply side issues rather than demand side. In Andhra Pradesh alone, the data from our study shows far lower coverage than the DLHS III and this needs further exploration.

## E) Newborn Care

The pattern shown by the data on newborn care is also instructive. Although newborn visits have not yet been introduced, about 27% of the ASHA in Dibrugarh, and 55% in Karimganj were making home visits for the newborn. It is fortunate that the sample included Angul in Orissa which acts as the best practice in this sample. We can see that a high performance on newborn care (85%) has spin off effects in all aspects of ASHA functionality - most dramatically in coverage. (although there is still a last 15% to be reached!!). When newborn care is incentivised, ASHAs in Angul, received a more reliable, higher and more accountable payment and are the best paid ASHAs of all our district case studies. Programme perceptions that community level care is important combines with policy support for such care and supervision and

incentives to yield an effectiveness on all areas in which the ASHA is skilled. Training on some aspects, especially child nutrition and post partum care remain very weak, even in Angul, but now that the systems are in place and the gap is known it can be easily corrected. It is worth noting, that even in Nayagarh district of Orissa, though nowhere near Angul, the performance on many parameters of care in newborn are better - perhaps a reflection of the programme theory and support mechanism in the entire state of Orissa.

In most other states newborn visits are still only up to 40% among families who are under ASHA coverage of any sort. Even this level of functionality means a large number of visits – in absolute numbers and this could have resulted in better health outcomes, but then the skills and support are just not in place. This opportunity has not been optimally made use of.

## F) Common Childhood Illness

In care during illness of the sick child, irrespective of programme theories and support, we find that at least 70% of ASHAs are being consulted. Given that the ASHA is the latest entrant in the field, where a range of other providers including non qualified providers are already in place, this data indicates the level of acceptance that the ASHA enjoys in the community. However despite her being “functional” on this task, her effectiveness is lower. The opportunity to provide appropriate care appears to have been lost in the majority of cases, due to lack of skills, supplies, or limited support. For example the number of cases of diarrhoea, for whom the ASHA was able to supply ORS from her kit, was 27% in Bihar, 37% in Jharkhand, 56% in Rajasthan, and 54% in Assam. Among the high focus states, Orissa alone did much better with 83% of service users reporting that the ASHA had supplied ORS. It does seem that even where the ASHA was not supplying ORS she was making referrals in the remaining cases, but even then 20% to 35% (Jharkhand) of children with diarrhoea in most states, excluding Kerala did not receive ORS. If we look at knowledge and skills, in addition, we note that the ASHA’s knowledge in making home based ORS or in promoting higher fluid intake, or in counselling for continued feeding was uniformly low, with lowest rates being reported from Bihar and Jharkhand. The potential for saving lives through this function which has been one of the main reasons for introducing the ASHA programme, is not being realised. Uniformly below the block, even amongst department employees, this function of responding to the felt needs of the community and especially the sick child is felt as an urgent necessity. The argument that is being made against any community care role (referred to as the “service provision” role) is more common at higher levels in the implementation chain. It also indicates that ASHAs themselves have shown considerable “agency” in responding to community needs. Better performance in Orissa indicates a better understanding of the community care component at all levels of the system including the leadership.

## G) Family Planning

The ASHA’s knowledge on family planning as judged by a response on contraceptive advice to be given to a newly married couple is uniformly high in all states, ranging from 82% to 98%. Counselling for family planning is low



in all high focus states except for Orissa. In term of referral for service, the emphasis seems to be more on female sterilisation which is largely in keeping with the programme priorities on the field. ASHA were asked to report on number of successful referrals in the past six months. Averaging this data at about 1-2 cases per month, the figures were as follows: 63% in West Bengal, 35% in Bihar, 25% in Orissa and AP with less than 25% of ASHA in the remaining states. Low functionality is poor incentive payments, poor support and poor availability of services.

## H) Infant and Young Child Nutrition

In terms of functionality in the case of nutrition the two indicators used are routine household visits and nutrition counselling as reported by ASHA. The proportion of ASHA that stated making routine household visits ranged from 57% in Jharkhand to 97% in Kerala. Of the high focus states, 88% ASHAs in Orissa reported making routine household visits. The figure was less than 70% for the rest of the high focus states. 26% of ASHA in Assam, 39% in Bihar, 47% in Jharkhand, 54% in Rajasthan, 71% in Orissa, 73% in West Bengal, and 88% in Kerala and AP reported providing counselling services for nutrition. Knowledge on exclusive breastfeeding is over 80% in all states except in Orissa where only 70% of ASHA knew that the baby should be exclusively breastfed for six months. On the issue of adding fats and oils for complementary feeding, the knowledge levels were much lower, ranging from 1% in Orissa to 44% in Rajasthan. The higher knowledge and functionality on nutrition in Rajasthan is accounted for by the fact that the ASHA were part of the ICDS system, and probably had been trained with more rigour in nutrition topics. Effectiveness on nutrition was assessed on two parameters reported by mothers of children between six months to two years of age. On the proportion of children who were regularly using services of the Anganwadi the figures ranged from 84% in Andhra, 75% in Orissa, 69% in Kerala, 68% in West Bengal (48% in Malda and 89% in Birbhum), 62% in Jharkhand, 50% in Rajasthan, 41% in Bihar, and 23% in Assam. Regarding the proportion of children who were given complementary feeds at six months of age, the figures are low in most states, except for Kerala and Andhra with about 72%.

## I) Communicable Disease

TB and Malaria: ASHAs do play a role in both TB and Malaria. In the case of TB, functionality among the ASHA is high when considering the number of TB patients she reports. 71% of ASHA in AP, 64% in Bihar, 62% in Orissa, 55% in West Bengal, 52% in Rajasthan, with 50% in the remaining states reported that they knew of TB cases in their area. Of these 90% of ASHA in AP, 79% in Bihar, 95% in Orissa, 83% in West Bengal, 68% in Rajasthan, 84% in Jharkhand, 87% in Assam, and 77% in Kerala reported providing DOTS treatment. Given the overall prevalence of TB of 0.25 per 1000 the ASHAs functionality on this can be considered to be adequate. In the case of Malaria, knowledge levels as determined by knowing that a blood smear is needed to diagnose malaria were over 85% of ASHAs in Orissa, Assam, AP and Jharkhand. Even in the other states this figure was over 70%. However on knowledge of the drug of choice for malaria, the figure was 87% in Kerala,



66% in Assam, 74% in Rajasthan. In the rest of the states fewer than 45% of ASHA were able to state this correctly. This indicates a wide gap in knowledge between diagnosis and management of malaria.

## J) Community Mobilisation

The most consistent way in which ASHA plays this role, is by her participation and leadership in village health and sanitation committees. The study also shows that of those ASHAs who recognise the presence of marginalised sections in the village, a small but significant percentage take affirmative action to reach out to them - in the form of more household visits, more health camps or more efforts at mobilisation for the immunisation sessions. For example, about 68% of ASHAs from Kerala reported making more frequent visits to groups they considered marginalised, followed by 26% from Assam and 43% from Andhra Pradesh and less than 15% in remaining states.

About one fifth of ASHAs are active in mobilisation to secure entitlements and this has much to do with background characteristic of the state and district context and her own agency. Most commonly mobilisation on water and sanitation issues, followed by action for securing health care entitlements of the sub-center or anganwadi centre. Even on issues like domestic violence and anti-alcohol campaigns there is a modest level of activity - more in states which have a tradition of mobilisation in that area. Thus 33% of ASHAs in East Godavari were active against alcoholism in their villages. These are not high levels of achievement but it shows the potential to build upon this dimension if we so plan.



## K) Tying up with the Private Sector

There is no evidence of the ASHA charging fees, setting up private practice, becoming a Dai or a tout of the private sector. After five years of the programme we can safely say that these much feared problems do not exist. This is not to deny anecdotes. There is anywhere from a 1% to 5% range of private sector commissions across the states and that could generate a huge number of anecdotes. Exceptions to this are 9% in East Godavari, 11% in Bundi and 17.5% in West Singhbhum. There is no significant preferential referral to the private sector evident in any state. For example in referring a case of childhood diarrhoea to a private doctor, it was less than 5% in all states. Exceptions were 22% in Bihar, and 15% in Jharkhand. For cases of ARI, referral to private sector the pattern is the same, but 39% of cases in Bihar are referred, 14.3% in Bundi in Rajasthan, and 12% each in Khamman in AP, Birbhum in West Bengal and the two districts of Jharkhand. The highest for any district was 52% in Purnia. These referrals to the private sector could be due to the lack of alternatives, more than anything else.

## L) Conflicts Amongst Peripheral Functionaries

There is no evidence of any major conflict between ANMs, AWWs and ASHAs though this is one of the most commonly heard problems as perceived by the programme managers. There could be many reasons for this: One, because the ANM has shifted her work burden onto ASHA and there is no reason for

conflict. Two, it is because the early conflicts are all over, and each is used to the other being there and no longer feels threatened. Three, it is because the incentive is now clearly in different silos and there is no competition for the same incentive. Thus for institutional delivery only the ASHA gets the incentive, and for family planning the ASHA almost never gets any. In overview this conflict was never such an issue except when these three workers were set at each other by, "the same incentive having to be given to only one of the three; all of whom were declared eligible to get it; for a task that all three had to do as part of their job descriptions." With that incentive conflict resolved, by order from above, (as in the case of the JSY incentive where only the ASHA is eligible to get it), or by the field from below (the sterilisation incentive, where in practice ASHAs are rarely availing of this) - this conflict is over.

## M) Voice of the ASHA



The Voice of the ASHA as heard through the response to the questionnaires is quite instructive, on her own perceptions, requirements and sense of direction of what the programme should do. We have already discussed the reasons for her opting to become ASHA. In response to the question of what she likes most about her job, the most common reason cited are the ability to help others, win respect in the family and community, contribute financially to the family, and in about one thirds, the ability to provide better care for her children and enhance her own skills. In terms of the support she requires to perform better, about 70% to 90% articulated the need for better training as the single greatest requirement. Timely replenishment of her drug kit and monetary support were voiced but at a distant second. The demand for more monetary support is highest in Kerala, (77%), followed by West Bengal (60%), Bihar (48%), and the remainder below 40%. For timely replenishment of drug kits the requirement is expressed most in Orissa with 56% and all other states being in the 30% to 40% range.

## N) And in the Long Term

One concern of many stakeholders is unionisation and the demand for regularisation of services. As we can see from the data, this is only one of her many demands, and by no means the first priority. There is no clear relationship between felt need for more monetary support and role definitions (service provider, a link worker or an activist). If anything, the relation is strongest, where the perception of the ASHA and her managers is most akin to her being seen as a link worker without any element of activism or any ability to provide services to the community. The challenge would be to ensure that the ASHAs potential to facilitate change is not undermined by the quest for her rights and that her service towards saving lives and mobilising for change is not undermined by the denial of her rights. This would require a clear long term vision of the programme which understands and builds on the wide variety of subjective desires and objective needs. Those who want to be voluntary are supported and incentivised to be so, and those who want regular employment are provided adequate opportunities to enter training programmes to upgrade their skills, especially as nurses or paramedical staff.

## V. Is the ASHA Programme Working?

The selection of a limited set of functions on which she is supported by the health system, depends on the way programme managers at different hierarchical levels, ASHAs and their facilitators have interpreted and modified the central guidelines. This has meant amplifying some part of the guidelines and downplaying or even ignoring some others. This phenomenon occurs at all levels, though most stakeholders were not explicit or even conscious of making their own interpretation of the rules. This is not necessarily a bad thing, but as evaluators we were conscious of this phenomenon and factored it into the analysis.

There are three clearly different explanations of how the ASHA programme will work. Each of these three programme theories or "frameworks of understanding" as we have called them are likely to make different meanings of the evidence being placed before them. But we hope that as everyone, including the researchers, mull over the data, we come closer together in our understanding of the programme.

In the first framework of understanding, the ASHA works by generating demand. Services, *all* services, are provided by professional health care providers, and the ASHA assists by ensuring that their services are fully utilised. The ASHA *cannot* and *should not* provide any other type of care, though some health education leading to changed health practices; especially those that lead to greater consumption of health services are welcome. Typically the officials who hold this view look only to the public health system for providing this care, but there is a section of administrators and public health experts who feel that private health care providers should also be roped into this response. In this understanding, the ASHA's getting into service provision is not desirable because a) It would make the public health system provider lazy and b) The ASHA would then set up practice as quacks and c) The ASHA would then demand for becoming permanent staff. Mobilisation for attending the facility is welcome, but all other forms of mobilisation are not welcome or at least not feasible. Most votaries of this view also hold that there is a constant strife between ANM, AWW and ASHA at the field level. They also would hold the view that better payments would lead to better coverage. This framework of understanding is highly prevalent in the state level amongst all implementers and in the district level amongst medical professional leadership of the programme.

In the second framework of understanding, the ASHA is effective because she reaches out to many sick children and newborns with a level of care that is life saving. If she fails to reach the child no one else will. Potentially the AWW can, but in practice because of structural issues, the AWW is not doing so. This theory recognises how important it is for the ASHA to have the support of a responsive health system that heeds her referrals for saving lives and for her own credibility and sees the demand generation role as a major role. But it also holds that those who are unreached or marginalised can be reached only if their felt needs are being responded to. This theory also recognises that when the system is not adequately responsive, the ASHA should also be trained and supported to be activist enough to persist, push for entitlements and mobilise weaker sections to access these services as their rights. But given the structure of implementation, there are limits to mobilisation. The



key issue is that even if the system was responsive, without actually being able to respond to illness needs at the home level, the ASHA programme cannot be expected to have any impact on child survival and the real potential of this programme is lost. Drugs are not central to this response, but an active form of counseling which requires higher level of knowledge and skills is the most important requirement and actually constitutes a form of service provision. However some drugs – notably – paracetamol, co-trimoxazole (or other anti-biotics), chloroquine (or other anti-malarials), and ORS are critical to her work. Fragmented payments by incentivisation of specific tasks should not be the sole source of support and should be combined with fixed payments. This view is the most prevalent view of the programme in professional public health literature, in much of civil society and in the national leadership as represented in the ASHA Mentoring Group. It is also a view commonly held by ANMs, ASHAs and most block level functionaries. In Orissa, the state leadership also has this understanding.

In the third framework of understanding, the ASHA programme works because her role in securing community participation and mobilisation is effective in itself. It enables facilitation tasks, reaches the unreached, and mobilises communities into putting pressure for functional health systems. Payments are considered to be a hindrance. Service delivery would distract, although some basic services are useful as a supplement to mobilisation. Not too much is expected of the ASHA in saving lives in the field. Some would say it is because she is not qualified for this, and others would say it is because the system cannot be expected to provide the high degrees of support and training required to realise this. One sees a strong evidence of such views in Andhra Pradesh (especially the training content) and Jharkhand programmes. It is also a prominent view among some sections of civil society and some sections of state and national leadership. As about 26% of ASHA in Andhra Pradesh report action against alcohol, and about 28% of ASHA in Kerala and Rajasthan reported being active on issues of domestic violence. 62% of ASHAs in Jharkhand reported taking action on water and sanitation issues.

We present the functionality and effectiveness of the ASHA in relation to these different frameworks of understanding and raise some key corollary questions that emerge within each framework, when each ‘framework of understanding’ interacts with the evidence.

## A) Outcomes – As Facilitator-link Worker



As a limited facilitator of two services, i.e., getting pregnant women to the institutions for delivery and getting pregnant women and young children to the immunisation session or VHND as it is called the ASHA is remarkably effective and the programme is clearly “successful.” If one is in the first framework of understanding, the ASHA and the ASHA programme should not be held responsible for anything more. The impact of these two changes on health indices would be more determined by the existing responsiveness of the health systems - its ability to deliver services in the facility and in the VHND platform. Those who would consider an ASHA limited to their roles as adequate should reflect on the following:

Does the poor coverage reflect the failure to promote facility utilisation in those sections that are not already sensitised to it? Are most of the users

of the services "anyway" or "already" users of the service? This is clearly so in a context like Kerala, because of such a good baseline. But to what extent is it so in other states? The finding that in many states, that women who finally opt for home delivery have usually not been met by ASHA or offered any other services is a matter of concern. It may be unfair to dismiss ASHAs as merely being commission agents as those in other frameworks of understanding do, but then there is a need for those who passionately believe in a limited link worker ASHA to at least ensure universal coverage for these two limited goals.

Many marginalised sections may respond better to the call of institutional delivery or immunisation if their felt health care needs, particularly illness in the young child are attended to.

Is it that the promotion of services is so narrowly linked to what is incentivised that even related changes in health behaviour needed for effectiveness in health outcomes are not being achieved?

Within this programme theory there is still scope for improvement in promotion of family planning services where indeed ASHA, ANMs and AWWs compete over the incentive, and across the board, the ASHA does not seem to be getting any incentive. Improvement in this task requires better delivery of the incentive for this – with targets to each ASHA.

Facility level care and quality of outreach services would have to improve dramatically in the high focus states for the "only demand side" ASHA to be effective. Many state programme managers have a stated commitment to enhance the activism component, and this could be built on to improve coverage. Some spirit of activism could help widen the scope of interventions to associated health care practices like hand washing or adequate complementary feeding, or even to three ANC check ups instead of being so narrowly limited. But eventually those within this understanding must reconcile to the fact, that no major increase in child survival is likely from an ASHA limited to this "facilitator" role.

## B) Outcomes – In Community Level Care Provision

As a person responding to health care needs of the community and effective in changing health behaviours, the success of the programme at this point of time is limited. If we understand that much of child mortality is due to diarrhoea or ARI and most lives could be saved in our context by the provision of immediate home based first contact care or that most newborn deaths can be averted best by providing essential newborn care at facility or at home, followed by home based follow up for a month, or that there are many child death due to malaria which needs prompt diagnosis and appropriate care, then the current ASHA programme falls far short. And yet, for both public health science and for much of civil society this was one of the main reason for embarking on and supporting the ASHA programme.

Orissa seems to be most responsive and effective on this dimension. West Bengal and Assam are functional on this aspect but need more inputs to be effective. The other states have to take this seriously – but for this they



would need to understand the ASHA as more than demand generation. The states could be encouraged by the finding that this is possible and there is considerable welcome and initiative for such care provision at the field level. ASHAs are already functional in care provision in about 50% of illness episodes and visiting newborns within three days, even without much encouragement. It is not the lack of motivation or incentives that is coming in the way. It is just that they need the skills and support to be effective. This is also the case with promotion of better health care practices and healthy behaviours. Currently monitoring and support systems are not even asking these questions of the ASHA and not reviewing the programme for achievements in these areas. Skills too are insufficient.



Kerala is also active on this dimension, but given existing health seeking behaviour for childhood illness and for care in pregnancy, the ASHAs value addition is not clear. In non communicable diseases, an ASHA limited to bringing adults to attend NCD camps becomes sub-critical. There is a need to invest her with skills of screening and routine follow up for diabetes and hypertension if she has to make a visible impact.

For those with this understanding of the programme, the questions are:

- How to build up skills when there is such great hesitation to invest in a supervisory and training structure?
- How to ensure regular drug supplies, when overall drug logistics is still so weak?
- How to make full use of the window of opportunity that exists because of the ASHAs current level of functionality, when incentives and monitoring structures fail to factor in these tasks.

Finding answers to these questions is most important to secure changes in health care practices as well as to save child lives through prompt and simple actions undertaken at the home and community level. There are best practices in the states from which we can learn how to address these issues.

What is important is to understand cause and effect on the challenge of building up supervisory and training structures. It is not that we cannot impart skills because training and supervisory structures are deficient. It seems more that these structures are deficient because at the level of implementation there is reluctance to concede these skills and functions. If that hesitation, partly a result of professional mind-sets changes, then the practical problems of building a supervisory structure and mechanisms of support can be resolved, more easily. So though success in this area is limited, given the nature and causes of limitations in training, support and incentivisation, the fact that so much progress has been made at the field level even in the so called poor performing states is encouraging.

### C) Outcomes – The Activist Dimension

The findings are that this role of ASHA as activist is rather limited. Though perceived as important at the senior levels, the more proximate (district and block) levels do not hold the same view. Even in states where there was a major initial thrust given in this direction, as in Andhra and Jharkhand this has

not been sustained in the nature of support provided, though even now, much of this initial energy sustains. Jharkhand did select NGOs for support, but either due to poor choice or poor support to the NGOs themselves, there was limited progress, and the state withdrew from this option. Yet in the absence of serious and systematic NGO involvement, it may be difficult to secure this dimension of ASHA as activist.

The first four modules completely ignored the activist aspect. Module 5 was introduced as a corrective. In Orissa and Assam module 5 has introduced many elements of activism, although to a modest extent. In other states including Andhra Pradesh, Kerala, Bihar, Rajasthan there is not much enthusiasm in introducing this module, and two years after its introduction, the module is yet to be rolled out.

What was existing mobilisation most associated with within a district? We looked for a number of statistically significant relationships. In Birbhum, ( $p=0.001$ ), in Nayagarh (0.02), in Purnia (0.014) and Khagaria (0.001), and in Trivandrum (0.035) there was a strong association of mobilisation with the active presence of a village health and sanitation committee in which ASHA was actively involved and irrespective of her formal position in it.

The findings demonstrate that community mobilisation in the form of VHSCs does pick up, especially after module 5. That activism could also mean greater efforts to reach marginalised sections within the village not only insist on accountability from health facilities has not become obvious to many functionaries. The design element that an ASHA helps by helping marginalised sections access health care facilities is not understood by programme implementers at any level.

The good news however, is that many ASHAs may have a better understanding of this dimension, and there is a large amount of "spontaneous involvement" in a wide variety of mobilisational roles. There are trends of mobilisation for the ASHA's own wages - but what we have traced is the wide degree of mobilisation that she has led or participated in for securing community entitlements. This needs to be built on. While financial reasons may be a driving factor in about half the ASHAs selected, any careful reading of the evidence should concede that altruistic reasons, such as community service also act as a driver in about half the ASHAs. This should not be dismissed out of hand merely because planners and implementers may lack such motivation. The insistence on planning for incentives and payments and career plans is good and needs to be encouraged. But planners must also plan to support and develop the voluntary and community service dimension of the ASHA programme. Those who subscribe to framework of understanding that activism is the main way that ASHA programme would be effective should recognise the limitations of achieving such a goal without a parallel structure of implementation. Since this is not desirable, they would have to focus on improving three dimensions of the programme to take this activist dimension forward: a). Sensitisation of the ASHA and the programme to reaching out to the marginalised, b). Building up mechanisms of meaningful NGO involvement either through appropriate central schemes or state level grant in aid mechanisms and c). A strong VHSC programme supported by NGOs to focus on community entitlements and provide the opportunity for ASHAs to contribute as an activist.



## VI. Recommendations

Based on these findings and analysis, we make the following recommendations.

### A) ASHA's Activities

There is an urgent need to reiterate to the states that the ASHAs role must be seen as being composed of four major activities:

- a) Home visits: Especially for those homes with a pregnant woman or a newborn or a child below two years or a malnourished child or a child below five who is sick.
- b) Attending the immunisation session or Village Health and Nutrition Day (VHND).
- c) Periodic and regular visits to a health facility for training, for programme review or for escorting a woman for delivery, or a sick child.
- d) Holding village level meetings.

### B) Optimising Outcomes for Time Spent

For efficient utilisation of her time and the considerable investment, programmers should maximize the health gains from each of these four opportunities. Home visits should be used for counseling leading to changed health behaviour. Home visits would also be used for providing a level of first contact curative care, universally accepted as being within the capacity of community health workers to provide. The village health and nutrition day and the village meeting should be leveraged for behaviour change communication and social mobilisation.

Currently home visits and the ASHAs attendance in immunisation sessions are missed opportunities for key community level health interventions. The two key requirements to ensure that the time spent on these activities translate into health outcomes include:

- Increasing the knowledge base and the skills of the ASHA through training and on the job supervision.
- Ensuring a health system that is responsive to her referrals and provides the requisite supply side inputs.

### C) Areas for Skill Building

In order to improve the effectiveness of the ASHA, and realise the full range of interventions that can take place through home visits, the village health and nutrition day in her work in wording of VHSCs, and coordinating VHSC, further skill building in the following areas is required:

- Improve the skills of counseling and inter-personal behaviour change communication in a number of areas related to nutrition, care in pregnancy, home based care of the newborn, and prevention and management of illness in the young child, and prevention of common communicable disease and promotion of good health practices. (The detailed set of competencies of the ASHA has been listed in the



Operational Guidelines for Maternal and Newborn Health, Ministry of Health and Family Welfare, 2010.) Much of this is not happening now, because the effort to monitor and support the ASHA on these activities and provide on the job mentoring to enable her to perform these functions effectively is not being emphasised. The training programme covers these areas, but skill building in counseling needs to be aimed for and accomplished.

- Build competencies to recognise and refer maternal complications, provide appropriate community level care (including first contact curative care) of newborn and child hood illnesses and other diseases such as malaria and tuberculosis.
- Build skills in village health planning and in organising her own tasks.
- In areas where non communicable diseases are the priority, and RCH issues are adequately addressed, build the skills of the ASHA for task like screening for blood pressure and diabetes.

## D) Reaching the Unreached

To address the problem of inadequate *coverage* of the beneficiaries, the ASHA's role in reaching out to marginalised sections needs to be emphasised. The trend amongst ASHAs to limit their support in pregnancy to those women who are more likely to opt for institutional delivery needs to be corrected. Active sensitisation is also needed to convey what marginalisation means and the need to emphasise to the ASHA that she needs to prioritise these sections. In order to elicit a positive response to the department's priorities, from such communities, their felt health needs must be attended to. The evaluation shows that representation of SC/ST and the population coverage are not issues in the programme, but social and geographic barriers restricting coverage leading to a significant minority within the village who are not able to access ASHA's services is a problem. There needs to be a renewed emphasis and support to enable her to identify and overcome social barriers and to ensure that every single house in a rural area is allotted to one ASHA and that every house is reached by the ASHA.

## E) Advocacy for Health Outcomes

There is a persisting need for advocacy to explain to programme managers, the potential gains of having an ASHA in place. The Task Force Recommendations that set up the ASHA programme, and the document that emerged from this, (Accredited Social Health Activist (ASHA) Guidelines, Ministry of Health and Family Welfare, April 2006) should be made widely available. In particular the rationale of how the ASHAs' home visits can save child and maternal lives needs to be explained. This would be particularly important in blocks where the nearest referral point is not within the village, and hence without the ASHAs intervention, there would necessarily be a delay in identification and prompt provision of appropriate care.

Where skills to save lives have not been imparted, no expectation should be made of health outcomes from a ASHAs role, except to the limited extent that increases in institutional delivery and immunisation rates alone would make a difference. Globally, neonatal deaths account for nearly 40% of





under five deaths, 13% from pneumonia, 14% on account of diarrhoeal deaths, malaria 9%, and measles 1%. (WHO, 2008). Other studies have demonstrated that two interventions—oral rehydration therapy and breastfeeding—were each estimated to prevent over 10% of deaths. Six further interventions could each prevent at least 5% of child deaths, and these include ITMs, improvement of complementary feeding, antibiotics for neonatal sepsis, antibiotics for pneumonia, antimalarial treatment, and preventive zinc supplementation<sup>7</sup>. An 18–37% reduction in neonatal deaths can be achieved with outreach and family-community services alone. Effect at the family-community level might also be increased through more comprehensive community case management of illnesses in newborn babies, such as neonatal sepsis and birth asphyxia, effectively taking more clinical care into the home and community<sup>8</sup>. Other studies show that community health workers can undertake these tasks provided they are well trained and supported. Thus all of these interventions are well within the purview of the ASHA and the life saving potential of home based newborn care has also to be explained more rigorously.

Mechanisms that provide incentives for these activities, and regular drug kit refills and on the job training are essential support this work. The number of children identified and admitted as sick newborn or diarrhoea with dehydration or for pneumonia, or cases of malaria picked up by ASHAs could be easily monitored under existing systems. Such monitoring and feedback would enable maximising health outcomes of these interventions. Currently the main limitation to ASHA being more effective in these areas is not her own educational or even skill levels, but the quality of support she receives and perceptions of her role at higher levels of the implementation chain. As long as this persists, the ASHA programme would fall far short of its potential.

## F) Advocacy for Activism

Advocacy to explain the activist dimension is also essential. NGOs associated with the Advisory Group on Community Action (AGCA), community monitoring process and the National ASHA mentoring group must be supported by the MOHFW at the national level to explain the programme, especially the rights component, to the programme managers at district and sub-district levels.

The activist component should be understood primarily as reaching out to marginalised sections with a greater effort, and ensuring that people are mobilised at the village level to utilise services and undertake collective action needed to safeguard health, including access to health related entitlements. At the sub-district, level advocacy for the community care role is not so urgent, as stakeholders at this level largely understand and agree with this aspect. But the ASHAs role as an activist for securing health care as entitlements would need explanation. The department would be a poor vehicle for facilitating this though with sensitisation even they would do better.

7 How many child deaths can we prevent this year?, Gareth Jones, Richard W. Steketee, Robert E. Black, Zulfiqar A. Bhutta, Saul S. Morris, and the Bellagio Child Survival Study Group\*, Lancet Child Survival Series, Vol. 362 – July 5, 2003.

8 Evidence-based, cost-effective interventions: how many newborn babies can we save?, Gary L. Darmstadt, Zulfiqar A. Bhutta, Simon Cousens, Taghreed Adam, Neff Walker, Luc de Bernis, for the Lancet Neonatal Survival Steering Team\* Lancet Neonatal Series, March 2005.

## G) Role of ASHA Mentoring Groups

Strengthening and orientation of ASHA mentoring groups at the state level would be essential for sensitisation of state level officers. Here the challenge is to bring in public health expertise from civil society that has worked in the theory and practice of community health action to explain the link between community level care and child mortality and the minimum level of skills this needs. This was the vision with which the ASHA mentoring groups were created, but in most places they are too poorly functional or constituted without the participation of such a civil society representation to effectively play this advocacy role.

The national ASHA mentoring group, which is a carry forward of the task force that designed the ASHA programme and which in turn was constituted subsequent to an intervention made by civil society with the Prime Minister's office has also to recognise that it was not enough to have framed the guidelines. It has to make contribution to advocacy to explain and support the decision on a continued basis, if the programme has to yield results in terms of child and maternal survival and in terms of social protection from costs of care.

## H) Support to ASHAs

Improving effectiveness of the ASHA is directly related to having a strong support system in place. Such a system must have the following essential components:

- Drug kits and regular replenishment.
- Financial and non financial incentives to give value to the task and to compensate the ASHA.
- Monitoring Strategy.
- Supportive supervision and on the job mentoring.

Each of these are elaborated below:

### I) Drug Kit

Improvement in drug kit refill is important and ranks as the ASHA's third most important suggestion for improvement. Where ASHA facilitators are in place, they should be given the task. Where not yet recruited, one peripheral staff member, such as the ANM, should be designated as the ASHA facilitator and given the task of refilling the drug kit. A demand responsive logistic system reaching out to sector PHCs and to sub-centers is essential for maintaining the drug supply needed. The composition of drugs and supplies in the kit should reflect the understanding of community level care provision that saves lives of children.



### J) Incentives

The study findings highlight a range of issues related to the payment of incentives. The following recommendations emerge:



- i) Currently the ASHA incentives are mainly dependent on the JSY payment. The guideline (existing, but requiring emphasis) is that Rs. 200 is for promotion of the delivery, to be paid to the ASHA even if she does not escort. Any delivery from the village which is institutional should be eligible for the incentive. Verification of the ASHAs role in promotion could be kept at a minimum. Even a statement from ASHA or the mother would be enough. Rs. 250 is for the transport and paid to whosoever arranges and pays for transport. If ASHA does not arrange the transport, she is not entitled to it. Rs. 150 is for the escort function and is paid only if the ASHA accompanied the woman. The insistence on linking payment to the ASHA staying with pregnant woman for 48 hours is perverse and plays no role, especially since she is not equipped even for a birth companion role. Even the escort function should be seen as voluntary and not made mandatory. However we recognise that in a significant percentage of cases the ASHA does undertake escort function for a range of reasons in response to people's requests, and in such situations the hospital should facilitate the stay. A room for ASHAs to rest in and stay overnight, with access to toilets at every facility where ASHAs brings in pregnant women for delivery should be insisted upon. A facilitation desk in the CHC and district hospital to specially help ASHA and the patients she refers should also be insisted upon.
- ii) Across all states even where ASHA are active on promoting sterilisation they do not receive the full incentive. This needs to be attended to and where ASHA has made a claim and the beneficiary names her, even as one of the many promoters, she should get the incentive. In case another peripheral worker has equal claim to the incentive, there needs to be a mechanism to ensure that this does not become a source of conflict.
- iii) Incentives from all other sources are useful, but do not add up to a significant sum, per ASHA. The only exception is where visits to the newborn are included. The provision of incentives for newborn visits at Rs. 200 per newborn visited (as seen in Angul district) makes the amount received by the ASHA increase significantly. Based on these considerations, we recommend Rs. 250 be paid for a series of five visits to the newborn. In areas where institutional deliveries are low, this would result in the ASHA reaching home deliveries which are otherwise neglected. In low fertility areas, this incentive would add to the otherwise low sum that JSY alone currently provides.
- iv) Fixed monthly honoraria do not make a difference to the range of services provided or to the functionality of the ASHA. It is the nature of programmatic emphasis and quality of support that is critical. Performance based incentives certainly help improve the performance of the task to which it is linked. But whether this task is narrowly understood and performed like a commission agent, or undertaken in such a way that it impacts on health outcomes, again depends on the quality of training and support. For example motivation for an institutional delivery could be focused entirely on ensuring that the woman delivers in an institution, (a narrow definition), or as a part of enabling antenatal care, counseling for nutrition and contraception, etc. Incentivising newborn care makes the performance based amount add up to a substantial amount which is higher than what is being considered for payment under the fixed route. We note however

that the case for a fixed monthly honorarium is made by its votaries mainly on the rights of the ASHA, who is usually a poor woman and who is spending on an average three to five hours per day on this work. A basic performance based retainer payment linked to a set of monthly regular activities – maintaining her diary, maintaining her drug kit and dispensing from it, conducting home visits to all families at risk (pregnant women, women with children below 2, malnourished children,) once a month, holding the village women's meeting, and where she is the member-secretary convening the VHSC could qualify her for Rs. 500 per month, over and above which she would get a performance based incentive for specific activities.

## K) Monitoring the ASHA Programme

A system to monitor ASHA functionality and effectiveness needs to be put in place at block, district and state levels. The block level would use a set of indicators reflecting functionality on a range of services. The district would use a sub set of the block indicators, as appropriate, and the state needs only to know what in the appropriate performance of each block. These indicators would be based on data collected from ASHAs at the monthly meeting or in the training programme or on data collected and verified by the ASHA facilitator. The block, district and state would in addition review ASHA effectiveness through health outcome indicators from the HMIS already being generated. Such a system is possible, and indeed essential if there is a system of facilitators, block coordinators and district coordinators in place. It would be very difficult to implement without full time staff dedicated to supporting the ASHA and VHSC programme. The block (and units below) could maintain an updated list of all ASHAs in the block and would update it as and when changes take place. The list would specify how many families are allotted against each ASHA's name. This would ensure that no family is being left out. The list need only have the ASHAs name, the sub-centre area she comes under, her village and the number of families covered. A more complex list would be deterrent against accurate and timely completion. At the district level only the names of ASHAs need be registered. The district should specify the authority and the process by which an existing name on the register is removed and a new one added.

Though drop-outs are not a significant problem, it is important to be able to decide when an ASHA is to be named as non functional. If states have a monitoring system in place, it would be easy for the district authority to decide this. The state should issue guidelines that declare who is competent to notify an ASHA as "dropped out", after what process of verification, and what process of dialogue is required to get her working again. The exit interview must be recorded. The guidelines should also specify by what process a replacement is selected, trained and deployed.

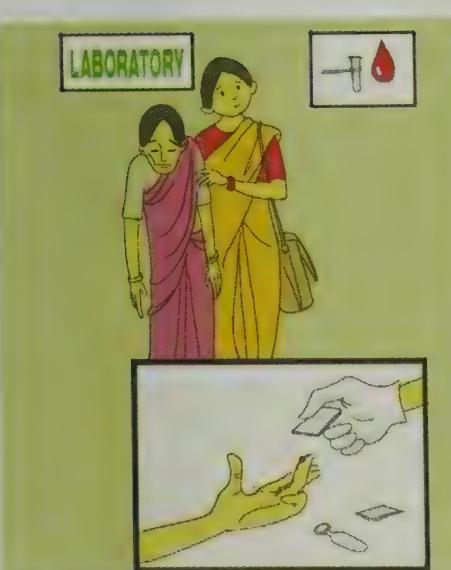


## L) Support, Training and on the Job Mentoring

To implement the monitoring strategy and to provide on the job support to the ASHA, to keep up the pace and quality of training, a support structure within the district is essential. The Financial guidelines/Implementation framework for the ASHA support system, MOHFW, July 2006, laid out clearly the financial

norms and the support system needed to support the ASHA. However, implementation of this has been weak in all states, except in Assam and Orissa. In particular emphasis must be given to:

- i) Ensuring at least one facilitator for every 20 ASHAs, and a block level coordinator, and a district level team in place. Promoting the best performing or best qualified ASHA who is also available for this task as the first option is a 'best practice' reported from several states.
- ii) Given the expansion of the programme, the district team should include, in addition to the specified, district coordinator and data management assistant at least five full time trainers. In addition there should be a district training team of another fifteen persons, who can spend a considerable part of their time on training. Thus a team of twenty trainers (two per block) for training in current and future modules. This function of training could be outsourced to a suitable NGO or training institution who would maintain a district training site for this purpose. The content of the training should address the skill gaps to enable the ASHA to become more functional and effective. Every ASHA should have opportunity to attend a review meeting/training seminar at least once a month, and should be visited on-site by her facilitator at least once a month.
- iii) Clarity on objectives (especially on the seriousness with which we would like the ASHA programme to impact on maternal and child mortality) should drive the skills encompassed in the training content. In the non high focus states the value addition of ASHA to institutional delivery and immunisation rates is minimal and her work may be focused on other RCH indicators, reaching the minority marginalised section which is left out and introducing elements of non communicable diseases or other local priorities as appropriate.
- iv) Every state must have in place a state level ASHA resource centre or equivalent that would provide:
  - Overall support and guidance to the ASHA programme.
  - Serve as the secretariat for the State ASHA mentoring group.
  - Develop and Manage an ASHA data base, compiling information from the district monitoring structure.
  - Conduct periodic sample surveys and evaluation studies.
  - Develop state specific communication aids and training material.
  - Build a full time team of state level trainers who would be part of the state training team.
- v) A grievance redressal mechanism, based in every district headquarters, is essential for ASHAs, as recourse for problems with payments and with any other aspect, including lack of support, lack of medicines in the kit, or being unfairly dropped.



## M) Role Clarity and Synergy

**ASHA, ANM and AWW:** Based on data from the AWW, ANM, ASHA and service user questionnaire, and our analysis of the strengths and limitations of the ASHA programme, we suggest the following clarifications as regards the AWW and ANM roles in relation to the ASHA's roles and responsibilities. We

note that all three actors have overlapping roles. The section below clarifies the main responsibility/accountability of each in relation to the other in five major activities at the community level.

**Home visits:** This is seen as one of the ASHA's primary responsibilities. The ASHA will make home visits, prioritising households with a pregnant woman, a newborn (and post natal mother), children under two, a malnourished child and marginalised households. She would also visit only child under 5 with an illness, though all families are encouraged to come and meet her for minor illness - and not wait for her visit.

The role of the ANM in home visits is to support the ASHA in making joint visits to the homes of those who do not attend VHND but need ANM delivered services, to post partum mothers, to sick newborn and children who need referral services but have been unable to go and those families with whom the ASHA is having difficulty in motivating for changing health seeking behaviours. Though the ANM is expected to make home visits, given her work load, she is able to do this only rarely. Using the ASHAs more extensive home visits, and thus selectively prioritising the houses that the ANMs would have to visit, adds value to the tasks of both.

The AWW is expected to make home visits only to families where there are children under three with a focus on nutrition counseling and those who do not attend the Anganwadi centre. The ASHA is primarily accountable for illness care and counselling on health practices, though she would also help in nutrition counselling. The AWW is primarily accountable for nutrition counselling and growth monitoring though she would assist in illness care as well.

**Village Health and Nutrition Day:** All three play a role here, with the ANM providing the service and the other two playing a supportive role. The ANM provides immunisation, antenatal care, identification of complications, and family planning services. She also provides a supply of IFA tablets and oral contraceptives to the ASHA to be dispensed to pregnant and lactating mothers. The AWC (Anganwadi Centre) serves as a venue for the VHND, and hence the AWW is required for making this possible. The AWW also provides Take Home Rations to pregnant and lactating mothers and for children under three. Here the role of the ASHA is to mobilise women and children to attend the VHND, through motivation and counseling. This task entails that the ASHA carries out counseling and conveys the key health communication messages as appropriate. The dissemination of such messages could either take place at the VHND or while mobilising mothers and families to attend the VHND. ANMs also are charged with counseling roles, but the time and space they have for contact is inadequate when combined with service delivery, especially in the high focus states.

**Village Health and Sanitation Committee Meeting (VHSC):** Convening village level meetings of the VHSC or women's groups is the responsibility of the ASHA. The ANM and AWW are expected to play a supportive role in helping the ASHA conduct the meetings, including the development of village health plans. As part of this task, the ASHA is also required to identify those marginalised sections that are getting left out, and not covered by services in any of the for a discussed above. The ASHA should take action by reaching out on her own, or enlist the support of the VHSC to improve access to services of these sections.



**Escort services to facilities:** This is only required of the ASHA. The escort for delivery is incentivised currently at a transactional cost of Rs. 150 (part of the JSY-ASHA package). This is also required for newborn referrals as well. In many other situations where escort becomes necessary, especially for pregnant women and children, it should be encouraged. All escort functions should be incentivised, but voluntary – meaning that the ASHA would be required to provide it only if the family needs the service and if the ASHA's personal circumstance allow for her to go along. Making it mandatory is neither desirable nor feasible.

**Record Maintenance:** This is a prime function of the ANM and the AWW and should not be passed on to the ASHA. The ASHA does have a diary to record her own activities, but this is only for the purpose of payment and documentation. She also has a register but this is only to enable her to track those in need of services and help her organise her work. The drug stock card is for her use to record her drug supply. The ASHA would not, as a rule have to submit monthly reports and formats. The ANM and AWW should maintain a tracking register and record of service delivery for the services that they deliver.

## N) Involvement of NGOs

Pari passu with the ASHA programme, states need to revitalise the NGO component of the NRHM to support the ASHA and the VHSC programme. NGO involvement is more or less a pre-condition for the rights aspect of the programme and the mobilisation aspect of the programme to be realised. NGO involvement is also essential to ensure that the process of capacity building and support are more broad based and expand the pool of assistance for the ASHA from such community based organisations.

## O) Village Health and Sanitation Committees

The programme management structure of the ASHA programme should also give attention to building vibrant Village Health and Sanitation Committees. States, should ensure training of VHSC members and building the ASHA's capacity to serve as a key facilitator of the VHSC and village planning process.

## P) Building Convergence and Cooperation



Convergence with PRI and the AWW and ANM appear to be positive. States should be encouraged to build upon this, by promoting joint training programmes and programme review meetings. No situation should be created where the same financial incentive has to be contested in between different health workers, especially when that work has to be done cooperation between all three. Barring such "created" conflicts, the tensions between peripheral health workers are low.

## Q) Long-term Sustainability

There is concern about the long term sustainability of the programme. The experience at five years indicates that if training and support continues, the

programme is likely to sustain. International experience also supports this. Criteria for replacement of ASHAs where needed would need to be put in place. Creating opportunities for further career prospects for qualified ASHA in ANM or nurses training courses is another way to encourage a turn-over in a very positive manner. Such prospects can only be enhanced by competency based training leading to certification of all ASHAs over the next three to five years. An approach to long term sustainability could be to divide the tasks of an ASHA as being based on a mix of: some tasks being done as voluntarism, some regular tasks compensated for by a fixed monthly performance based incentive and some variable tasks reimbursed on a performance based incentive.

## R) Possible Future Directions

If however there are pressures to increase their work-load, especially by introducing non communicable diseases, or political pressures to give her an Anganwadi worker like payment and service status, the balance between tasks and incentives must be reconsidered. One of the options would be to expand the service package to make for a six hour work day or to add a second ASHA. We must recognise that even if we were to replace every ASHA with a trained public health nurse or equivalently trained CHW, we would still be well below the international norms for density of 25 skilled health workers per 10,000 population in most parts of India. This point is made to emphasise that the possibility of an ASHA becoming a long term solution is not something to be feared but to be actively planned for.

## S) A Question of Values

When we undertake long term planning for the sustainability of this programme one dimension we need to keep in mind is the full picture of the ASHA's own expectations, motivations and perceptions of what support she requires as reflected in this study. Monetary compensation is certainly one of the drivers, but not the main one, much less the only driver of this programme. It is clear that despite the skepticism in sections of senior officials and experts, about ASHA's main motivation being community service and despite doubts about programme outcomes and sustainability, the programme enjoys popular political support and the ASHA commands the respect of the community and is driven by her enthusiasm to contribute despite the odds. We need to forge a way forward that builds on the ASHA's own reiterations of community service as being her main motivating element and the concept of voluntarism and activism. At the same time we also need to ensure that we do not become exploitative of her service, and that we respect the need to value her services and compensate her adequately for her time. The challenge is to build institutional structures and organisational strategies that could provide her with the skills and the support needed to ensure her effectiveness in saving lives and promoting health, without losing the spirit of the programme.





“ During the Eleventh Five Year Plan, ASHAs will be trained on identified aspects of newborn care during their training. This initiative will be initially implemented in the five high focus States (MP, UP, Orissa, Rajasthan, and Bihar). To supervise and provide onsite training and support to ASHAs, mentor-facilitators will be introduced for effective implementation. The national strategy during the Plan will be to introduce and make available high-quality HBNC services in all districts/areas with an IMR more than 45 per 1000 live births. Apart from performance incentive to ASHAs, an award will be given to ASHAs and village community if no mother-newborn or child death is reported in a year.

*11<sup>th</sup> Five Year Plan document, 3.1.133*

“ The community should emerge as active subjects rather than passive objects in the context of the public health system.

*Para 125 pg. 64, NRHM Framework for Implementation, MoHFW, Government of India, 2005-2012*

“ In order to reduce infant and child mortality a continuum of care is needed at the community as well as facility level. Of the two main packages available for reducing child mortality, the HBNC operates at the community level and has a strong evidence of feasibility and reducing child mortality. It should be used to deliver care at home through ASHAs and ANMs.

*11<sup>th</sup> Five Year Plan document, 3.1.136*





“ Coverage of primary healthcare systems — with the engagement of community health workers — needs to be comprehensive and universal and accompanied by sustained delivery of health services.

*High level event on the Millennium Development Goals, United Nations Headquarters, 25 September 2008, Committing to action: achieving the Millennium Development Goals, Background note by the Secretary General.* ”

“ Given present pressures on health systems and their proven inability to respond adequately, the existing evidence overwhelmingly suggests that particularly in poor countries, CHW programmes are not a cheap or easy, but remain a good investment, since the alternative in reality is no care at all for the poor living in geographically peripheral areas. While there is a lot to learn, there is a lot we do know about making programmes work better: appropriate selection, continuing education, involvement and reorientation of health service staff and curricula, improvement supervision and support are non-negotiable requirements. These need political leadership and substantial and consistent provision of resources.

*Community health workers: What do we know about them?  
Uta Lehmann and David Sanders, School of Public Health, University of the Western Cape.* ”



## National Health Systems Resource Centre

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